Virginia Department of Behavioral Health & Developmental Services

DBHDS CUSTOMIZED RATE APPLICATION

PROVIDER INSTRUCTIONS:

- This application should be submitted by the provider requesting a customized rate.
- Providers should read the **Customized Rate Provider Guidelines** prior to completing this form.
- Providers are required to submit this application **electronically, in its original WORD format** to: DBHDScustomizedRate@DBHDS.Virginia.Gov
- A secure link should be requested by emailing DBHDScustomizedRate@DBHDS.Virginia.Gov.
- Providers are requested to send one application per email.
- The form should be completed in its entirety using N/A for not applicable.

SECTION 1.	**INDIVIDUAL/GENERAL INFORMATION**
Date Submitted	Click here to enter the date the **application is submitted**.
Individual Name	**LAST:** Click here to enter text **FIRST:** Click here to enter text.
Individual DOB	Click here to enter the individual's **Date of Birth**.
Individual Medicaid #	Click here to enter the individual's **Medicaid number**.
Individual Social Security #	Click here to enter the individual's **Social Security number**.
Individual Level/Tier	**LEVEL:** Click here to enter text **TIER:** Click here to enter text
In what region are supports being provided?	Choose an item.
SECTION 2.	**CSB/BEHAVIORAL HEALTH AUTHORITY/GENERAL INFORMATION**
CSB/BHA	Click here to enter the individual's **assigned CSB**.
CSB Support Coordinator	Click here to enter the individual's **assigned Support Coordinator**.
CSB Support Coordinator Email	Click here to enter Email Address.
CSB Support Coordinator Phone #	Click here to enter phone Number.
SECTION 3.	**PROVIDER/GENERAL INFORMATION**
Provider Name	Click here to enter the Provider's Name.
Provider Point of Contact	Click here to enter the provider **point of contact**.
Provider Business Address	Click here to enter the provider **street address**. Click here to enter **City, State, Zip**
Address where supports will be provided	Click here to enter the address **where supports will be provided**. Click here to enter **City, State, Zip**
Provider phone and fax #	**PHONE:** Click here to the provider fax number. **FAX:** Click here to the provider fax number.
Provider Email	Click here to enter the provider's **email address**.
Is the individual a former resident of a training center?	Choose an item.
How many beds is the home licensed for?	Click here to enter the **number of beds** for which the home is licensed for.
How many individuals are supported in the home?	Click here to enter how many individuals are supported by the agency.
Under what service is a customized rate requested?	Please select the type of service under which you would like to apply for a customized rate

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SECTION 4.	STAFFING
How many shifts occur in a 24 hour period?	Click here to enter.

How many staff (per shift) provides support in the home?

Shift	Number of Individuals	Number of Staff
Click here to enter.	Click here to enter.	Click here to enter.
Click here to enter.	Click here to enter.	Click here to enter.
Click here to enter.	Click here to enter.	Click here to enter.

1:1 Staffing

☐ **THE INDIVIDUAL REQUIRES INCREASED STAFFING RATIO OF 1:1**

Description:

Click here to describe why the individual requires 1:1, listing all of the associated support needs.

DAYS PER WEEK REQUIRING 1:1	HOURS PER DAY	INDICATE HOW MANY OF THESE HOURS ARE PROVIDED BY HIGHER QUALIFED STAFF	INDICATE THE LEVEL OF COMBINED EDUCATION AND EXPERTISE REQUIRED
☐**Monday**	Click here	Click here to enter text.	Click here to enter text.
☐**Tuesday**	Click here	Click here to enter text.	Click here to enter text.
☐**Wednesday**	Click here	Click here to enter text.	Click here to enter text.
☐**Thursday**	Click here	Click here to enter text.	Click here to enter text.
☐**Friday**	Click here	Click here to enter text.	Click here to enter text.
☐**Saturday**	Click here	Click here to enter text.	Click here to enter text.
☐**Sunday**	Click here	Click here to enter text.	Click here to enter text.

2:1 Staffing

☐ **THE INDIVIDUAL REQUIRES INCREASED STAFFING RATIO OF 2:1**

Description:

Click here to describe why the individual requires 2:1, listing all of the associated support needs.

DAYS PER WEEK REQUIRING 2:1	HOURS PER DAY	INDICATE HOW MANY OF THESE HOURS ARE PROVIDED BY HIGHER QUALIFED STAFF	INDICATE THE LEVEL OF COMBINED EDUCATION AND EXPERTISE REQUIRED
☐**Monday**	Click here	Click here to enter text.	Click here to enter text.
☐**Tuesday**	Click here	Click here to enter text.	Click here to enter text.
☐**Wednesday**	Click here	Click here to enter text.	Click here to enter text.
☐**Thursday**	Click here	Click here to enter text.	Click here to enter text.
☐**Friday**	Click here	Click here to enter text.	Click here to enter text.
☐**Saturday**	Click here	Click here to enter text.	Click here to enter text.

	☐**Sunday**	Click here	Click here to enter text.	Click here to enter text.

SECTION 5.	**STAFF QUALIFICATIONS**
☐ **The individual requires higher qualified staff to provide direct support**	**Please explain why the individual requires expertise/specialized staff to provide direct support:** Click here to enter text.

☐ **The individual requires programmatic oversight to be delivered by a staff member with higher credentials than what is routinely required; and who have a Master's degree or higher <u>or</u> a Bachelor's degree with combined certifications (e.g. BCBA) to provide any of the below listed supports.**

(Check all that apply and give a description)

☐**Direct support staff training, especially as it relates to changes in care plan; training which is evidenced based and/or evidence driven requiring adherence to support protocols.**
Click here to enter text.

☐**Develop protocols and implement the processes that deliver effective and safe, evidence driven interventions/plans of care resulting in outcomes that improve the daily life of the individual.**
Click here to enter text.

☐ **Monitor medical and/or behavioral data to assure proper implementation of protocols, including changing the protocols as needed as an individual navigates his or her environment successfully.**
Click here to enter text.

☐**Serve as a liaison and provide expert opinion during hospitalizations or crisis interventions to ensure that protocols are maintained and/or amended as needed to reduce or prevent future hospitalizations (whether medical or behavioral). For individuals with a history of, or who are at risk of law enforcement involvement; staff must ensure that law enforcement and others are advised, trained or connected to mitigate the risk of legal system involvement or action.**
Click here to enter text.

☐**Oversee overall medical or behavioral supports to ensure supports are effective and coordinated with external providers, CSB's, emergency services and that protocols address when and how to involve external providers.**
Click here to enter text.

SECTION 6.	**BEHAVIORAL SUPPORT NEEDS**
Mental Health/DSM-V Diagnosis	Click here to enter text.
Behavioral strategies/interventions that have occurred over the past 6 months (e.g. ABA, Therapy, Positive Behavioral Supports)	Click here to enter text.
Frequency and duration of <u>interventions</u> that have occurred over the past 6 months	Click here to enter text.

Frequency and duration of behaviors that have occurred over the past 6 months	Click here to enter text.
Describe any history of hospitalizations, legal system involvement, or crisis services required over the past 12 months.	Click here to enter text.
SECTION 7.	**MEDICAL SUPPORT NEEDS**
Diagnosis	Click here to enter text.
Health Interventions Required	Click here to enter text.
Frequency of health supports required	Click here to enter text.
History of hospitalization(s) over the past 12 months	Click here to enter text.
SECTION 8.	**OVERNIGHT SUPPORTS**
Describe overnight support needs to include any 1:1 or 2:1 staffing requirements	Click here to enter text.
List the frequency of supports required during overnight hours	Click here to enter text.
SECTION 9.	**DAY SERVICES**
Describe the individual's currently enrolled day services and/or activities	Click here to enter text.
Describe the specific skills or set of skills that the individual plans to build upon	Click here to enter text.
Describe any current barriers to participating in day services	Click here to enter text.
SECTION 10.	**FUNDING**
Describe all funding sources currently in use	Click here to enter text.
If there are services currently available to the individual but not in use, please give an explanation; especially as it relates to nursing services	Click here to enter text.

Describe the funding required to support the individual above and beyond currently utilized resources to include a breakdown of the specified cost	Click here to enter text.
SECTION 11.	**SUPPORTING DOCUMENTATION/REQUIRED ATTACHMENTS**

Providers are required to submit the following documentation with this application

*****Applications submitted without proper supporting documentation can be denied *****

☐ ISP Parts I through IV and the provider-completed Plan for Supports (Part V).
☐Behavioral Support Plan, where applicable.
☐Behavioral Data, where applicable (history of crisis, frequency of behaviors and interventions required).
☐Health supports data, where applicable (Medical reports, protocols, specialized supervision data, nursing care plan).
☐Most recent quarterly.
☐Staff credentials (Copy of certifications and degrees for all employees who will provide supports to the individual).
☐Crisis plan where applicable.
☐Staffing Plan **using DBHDS Template** found at www.DBHDS.Virginia.Gov.
☐Overnight support's data.